STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 12,187

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Appeal of)

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INTRODUCTION

The petitioner appeals the decision by the Department of Aging and Disabilities (DAD) "founding" a report that she abused two elderly adults. The petitioner seeks to have the report expunged from the DAD "registry".

FINDINGS OF FACT

1. D.A. and S.T. are elderly women who live in the same nursing home, although they have rooms in different sections of the home.

2. D.A. has diabetes, Parkinson's disease, hypertension and is incontinent. She is debilitated and not ambulatory. She is depressed and is often confused and disoriented. She is totally dependent upon nursing home personnel to help with all of her bodily functions.

3. S.T. has multiple sclerosis and is wheelchair bound. She also relies on aides at the nursing home for all her functions, including dressing, eating, toileting and getting into bed. She has a disease which somewhat alters her perception of reality and she frequently confabulates events. She can, however, respond to questions and relate events.

4. After waking on the morning of May 26, 1993, the two elderly women described above complained separately to two different morning shift aides that they had been mistreated the evening before by an aide named "B." while being put to bed.

5. Each resident was interviewed separately by the nursing supervisor who helped each to fill out a form. D.A. told the supervisor that "B.", who was especially assigned to her care, had slapped her in the forehead because she wet herself at bedtime. S.T. told the supervisor that "B." had told her to "shut up" when she was being lifted into bed. She also said that "B." told her that she would not be working there

anymore. Both women were very upset recounting the events. D.A. was perplexed and S.T. was tearful. The nursing supervisor identified "B." as the petitioner since she is the only aide with that name, was D.A.'s special caretaker and had helped out in S.T.'s room, in another part of the building, the night before.

6. After taking the information from the two women,

the nursing supervisor called DAD to report the incidents and called the petitioner to tell what had happened. The petitioner came in to review the statements and was told at that time that she would be discharged effective immediately. This action was taken by the nursing supervisor because she believed the two residents and because it was the nursing home's policy to discharge workers if there was even a "question" of abuse.

7. The petitioner had worked in the nursing home since October of 1992. At the start of her employment she attended an orientation at which she was made aware of the residents' rights and warned that abuse would result in immediate termination. She was also advised that the state became involved in such incidents and was told that workers were also required to report incidents with residents.

The petitioner had been an exemplary employee and had not been involved with any incidents with residents before that date. In fact, she had a close relationship with D.A. whom she had helped to become more sociable and outgoing.

8. During the third week of June, a nurse-investigator from DAD interviewed both of the alleged victims and the petitioner. The two residents made essentially the same statements they had made on their forms. The petitioner during her interview admitted that she had been in both petitioner's rooms on the evening in question. She stated that she was struggling to put S.T. into bed and when the elderly woman complained of pain, she told her "to be quiet." She also stated that she found D.A. already in her bed (she had climbed out of her wheelchair and put herself in bed) wrapped up tightly in a blanket she had wet. She denied hitting D.A. but allowed as how she might have been accidentally hit during the removal from bed. The investigator found the statements of the residents more credible as to the events. She was particularly impressed by the residents' disturbed affect and the fact that S.T.'s statement also included a quote made by the petitioner that she was quitting her job, a fact which no one else knew at that time but which later proved to be true.

9. On June 30, 1993, the petitioner was notified by the Director of DAD's Adult Protective Services Division that the allegations made by D.A. and S.T. had been substantiated. After the petitioner appealed that decision, the Commissioner reviewed the investigative decision and notified the petitioner on September 21, 1993, that the allegations were credible and that he felt substantiation was warranted because the slapping incident met the definition of prohibited "physical" abuse and the "shut-up" statement met the definition of prohibited "mental injury" found in the statute.

10. The petitioner, as it turned out, was not happy with her job at the nursing home and had actually placed her letter of resignation (giving two weeks notice) in the

nursing director's mailbox at the end of her shift on May 25, 1993. That resignation was not discovered by the nursing director until after she had discharged the petitioner the next day. The petitioner's decision was based on her dissatisfaction both with low pay and a stressful work environment caused by a lack of adequate staffing at the home. The night of the alleged incidents, which was an unusually hot

night, the petitioner was one of only three aides in attendance on a shift which should have had five attendants. Because of this under staffing, the residents had to wait longer than usual to get into bed.

11. Following this testimony, the hearing officer reconvened the hearing at the nursing home to take further testimony from the two elderly women in the hope of gathering more details and more specific information about the context of the occurrences. However, neither woman had much to offer in addition to their former testimony to the reporters. Neither woman recognized the petitioner, who was in the same room. The petitioner herself testified that their lack of recognition of her did not surprise her since both had difficulty remembering people and since she had not been in the nursing home in almost eight months. D.A., in response to questioning, recalled the incident and that she had been slapped in the forehead by her special caretaker, "B.". In response to a question as to whether the slap could have been an accident, D.A. said no, that she was hit because she was wet. S.T. remembered the incident as well and wept and became excited as she talked about it. She added that after she had been told to "shut-up", she thought, "Oh, no, is this the way its going to be?"

12. The petitioner again denied both incidents at the hearing. She also produced the testimony of another aide who had come into the rooms of both residents on that evening and who testified that she noticed nothing unusual in the behavior of the two elderly women and that neither seemed to be upset. She also testified that S.T. liked to complain and had boasted in the past that she could get people fired.

13. The testimony of the elderly residents and the petitioner is directly at odds. The hearing officer finds the testimony of the two elderly women to be more credible in this instance. There was no reason for either of them to fabricate these complaints. The simultaneous but separate reports of these two residents as to these incidents and their contemporaneous certainty as to the identity of the perpetrator make it highly likely that the reports are accurate. The anxious and upset affect of both women at the time of reporting and again at the time of re-reporting during the hearing add to their credibility. The consistency of their story was borne out through tellings and retellings to the aides, the nursing supervisor, the DAD investigator, the police and the hearing officer. In addition, S.T.'s story, which included the statement that the petitioner was planning to quit, turned out to be true, adding to the credibility of her whole statement. Finally, both residents' testimony about the time of day and the events which occurred, other than the abuse, were confirmed by the petitioner, making it very likely that the two women were accurately describing real events. Therefore, the testimony of the two residents is adopted as fact herein.

ORDER

The Department's decision is affirmed. The petitioner's request to expunge the report in question is denied.

REASONS

The Commissioner of the Department of Aging and Disabilities is required by statute to investigate reports regarding the abuse of elderly persons and to keep those reports which are substantiated in a registry under the name of the person who committed the abuse. 33 V.S.A. § 6906, 6911(a). Persons who are found to have committed abuse may apply to the Human Services Board for an order expunging the record at which time a fair hearing is commenced wherein "the burden shall be on the commissioner to establish that the record shall not be expunged." 33 V.S.A. § 6911(d).

The more credible evidence in this case indicates that the petitioner while engaged in her work as an aide at a nursing home, slapped one elderly woman, D.A., in the forehead because she was upset that she found her wet at bedtime. The more credible evidence also indicates that that same evening, the petitioner told another elderly resident to "shut-up" when she complained of pain while being lifted into her bed. The only remaining issue is whether these actions constitute "abuse" as that term is defined in the pertinent statute.

The statute which protects elderly adults defines "abuse" as follows:

(1) "Abuse" means mental or physical injury or injuries inflicted by other than accidental means, or any other treatment which places life, health or welfare in jeopardy or which is likely to result in impairment of health.

The statute further defines "mental or physical injury"

as follows:

(8) "Mental injury" means a state of substantially diminished psychological or intellectual functioning as evidenced by observable and substantial impairment.

. . .

(11) "Physical injury" means death or permanent or temporary disfigurement or impairment of any bodily function or organ by other than accidental means.

33 V.S.A. § 6902

The Commissioner concluded that the slapping incident constitutes physical injury and that the verbal incident was a mental injury. Under the Board's former decisions interpreting those provisions in the context of both the elderly and disabled, and child protective statutes, those incidents could not be so categorized. The slapping incident did not result in even a temporary disfigurement or impairment of any bodily function so as to label it a "physical injury". There is no evidence that the verbal insult, while upsetting to the petitioner, substantially diminished S.T.'s psychological functioning as shown by an observable and substantial impairment. A finding of a mental injury would necessarily be the subject of expert opinion, which was not presented in this case.

However, the statute protecting elderly adults from abuse does not limit abuse to only physical or mental injuries. The statute is also broadly written to include "any other treatment which places life, health or welfare in jeopardy or which is likely to result in impairment of health." The Board has previously interpreted the provision which defines abuse as "treatment which places...welfare in jeopardy" as protecting disabled adults from unnecessary and inappropriate physical force and intimidation by caregivers in group homes. See Fair Hearing No. 9716. The same reasoning would hold true for elderly adults in a nursing home environment.

In Fair Hearing No. 9716, the Board found that disabled group home residents who are forced to rely on others for their most basic needs, have an expectation of trust and security from their caretakers which must be maintained as an integral part of their welfare. In that case, the Board found that a caregiver

who roughly handled and shouted at a resident, had breached that sense of security and had, thereby, jeopardized the welfare of the resident. And this finding was made even though the incident appeared to be an isolated one and even though the caretaker had an otherwise exemplary record at the home.

The facts of this case are very much the same. These two elderly women were similarly dependent on the petitioner (and others) as a means to maintaining their most basic daily functions. Their welfare likewise hinges upon the sense of security and comfort provided to them. This special relationship is recognized by the nursing home administration and principles of respect and courtesy towards residents in "their home" were impressed upon the aides at the inception of their employment. The nursing home management also made it clear to aides working in the home that even a "question" of abuse would lead to immediate termination of employment. The petitioner has never disagreed with these principles or asserted that she did not understand their importance.

The actions taken by the petitioner breached the sense of security and comfort which D.A. and S.T. needed and were entitled to as residents of the nursing home. They were clearly both shocked and upset by the incidents and even though their memories of the petitioner have faded in the eight months which have passed, their memories of the events (and their reactions to the events) remained.

As the petitioner's actions put the two elderly women's welfare in jeopardy, it must be concluded that the Commissioner's finding of abuse should not be expunged, although a clarification should certainly be placed into the registry as to why those actions constitute abuse. The petitioner should understand that this substantiation is made to protect these elderly residents, not to punish her. The petitioner, as so many others in these circumstances, appears to be a decent person with a good work history and a genuine affection for her charges who was just having a bad night. Her short-tempered reactions that evening are easy to understand in light of general working conditions which were so unfavorable that she had decided to leave, combined with the hot temperatures on that specific evening. However, persons who work in these specialized care situations are held to high standards and are trained in the importance of refraining from venting their frustrations on fragile residents. When such an incident occurs, even once, the caregiver's fitness for such a role is immediately suspect and the protection of those in care becomes the paramount concern.

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